General Assembly **Amendment**

January Session, 2009 LCO No. **9130**

HB0615209130HD0

Offered by:
REP. SCHOFIELD, 16th Dist.
REP. FONTANA, 87th Dist.
SEN. CRISCO, 17th Dist.

To: Subst. House Bill No. **6152** File No. 315 Cal. No. 239

"AN ACT ESTABLISHING A CATASTROPHIC MEDICAL EXPENSES POOL."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective July 1, 2009*) As used in sections 1 to 9, inclusive, of this act:

(1) "Applicant" means a child or a family member of a child who is applying for payment or reimbursement from the pool for medical and related expenses for such child.

(2) "Child" means a person eighteen years of age or younger.

(3) "Commission" means the Catastrophic Medical Expenses Advisory Commission established pursuant to section 3 of this act.

(4) "Family" means a child, any siblings of such child and (A) one or

more biological or adoptive parents, (B) one or more persons to whom legal custody or guardianship has been given, or (C) one or more adults who have a primary responsibility to pay for medical care for such child.

(5) "Family income" means all net income from all sources received by a family on an annualized basis, excluding payments or reimbursements received from the pool.

(6) "Pool" means the catastrophic medical expenses pool established pursuant to section 2 of this act.

Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is established a catastrophic medical expenses pool to provide payment or reimbursement for medical and related expenses incurred for a child beginning January 1, 2010, whose family's medical and related expenses exceed the threshold levels set forth in section 6 of this act. The Office of the Healthcare Advocate shall administer the pool in accordance with the provisions of sections 1 to 9, inclusive, of this act and with the advice of the Catastrophic Medical Expenses Advisory Commission.

(b) Services, equipment and other expenses incurred for a child that are eligible to be considered for payment or reimbursement from the pool, subject to the limitations and exclusions set forth in sections 5 and 6 of this act, include, but are not limited to: (1) Durable medical equipment, hearing aids, medical or surgical supplies, therapy services and prostheses or orthotics that are covered benefits but which were denied in whole or in part because policy or plan limitations have been reached, except that payment or reimbursement from the pool for (A) wheelchairs and hearing aids shall be limited to once every biennium, and (B) eyeglass frames shall be limited to fifty dollars; (2) any health insurance (A) copayments, (B) deductibles, (C) coinsurance, and (D) other out-of-pocket expenses paid by an applicant, excluding premium payments; and (3) other items determined by the Office of the Healthcare Advocate or persons designated by said office pursuant to

subdivision (14) of section 4 of this act to be directly related to the medical condition of the child and necessary to maintain the health of the child or permit such child to remain at home rather than be admitted to a health care facility.

(c) The Office of the Healthcare Advocate shall make publicly available a list of medical and related expenses that are eligible to be considered for payment or reimbursement from the pool. Said office shall update such list each time said office makes a change and shall review such list at least annually.

(d) Nothing in sections 1 to 9, inclusive, of this act shall be construed to require said office or the commission to make any payment or reimbursement of medical or related expenses to an applicant.

Sec. 3. (NEW) (*Effective July 1, 2009*) There is established a Catastrophic Medical Expenses Advisory Commission to assist and advise the Office of the Healthcare Advocate to carry out the provisions of sections 1 to 9, inclusive, of this act. The commission shall consist of the Healthcare Advocate, the Commissioners of Social Services and Public Health, the Insurance Commissioner and the Comptroller, or their designees, and additional members appointed by the Healthcare Advocate that shall include one or more (1) members of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, (2) members of the general public, (3) licensed health care providers who currently provide health care services to residents of the state, (4) representatives of the health insurance industry, (5) representatives of employers that are self-insured, and (6) senior managers or human resources directors of a labor union that offers a Taft-Hartley plan.

Sec. 4. (NEW) (*Effective July 1, 2009*) In order to carry out the provisions of sections 1 to 9, inclusive, of this act, the Office of the Healthcare Advocate shall have the following powers and duties:

(1) To develop an application and establish procedures for applying to said office for payment or reimbursement of medical and related

expenses from the pool;

(2) To establish rules and procedures for determining the eligibility of applicants and the eligibility of requests for payment or reimbursement of medical and related expenses from the pool, including, but not limited to, (A) the documentation or information required from the applicant to substantiate the eligibility of the applicant or the request for payment or reimbursement, (B) methods to verify family income, (C) limits, if any, on the number of times an applicant may apply in a calendar year, (D) limits, if any, on the dollar amount that may be paid to an applicant in a calendar year, (E) methods to verify previous payments to an applicant, if necessary, (F) methods to verify that the payment or reimbursement sought has not been paid by insurance or provided free of charge to the applicant, and (G) methods to verify other available sources of payment have been exhausted;

(3) To establish an approval process, including, but not limited to, any criteria to be used to prioritize payments or reimbursements made from the pool, except that in the event the moneys in the account established under section 9 of this act are inadequate to cover all the requests made for payment or reimbursement, any applicant who is transitioning to medically needy status under the Medicaid program and who otherwise meets the criteria under sections 5 and 6 of this act shall be given preference for payment of reimbursement from the pool;

(4) To establish procedures for an applicant notification process, including, but not limited to, the time frames for said office to approve or deny an application or request for payment or reimbursement and for applicants to submit additional information if a denial was based on incomplete information;

(5) To establish a list of services, programs, treatments, products and expenses excluded under subsection (c) of section 6 of this act;

(6) To develop payment rates in accordance with subdivision (1) of subsection (a) of section 7 of this act;

(7) To establish criteria for and procedures to (A) preapprove payments pursuant to section 7 of this act, and (B) make payments or reimbursements, including, but not limited to, the method of payment and time frame for said office to process such payment;

(8) To establish procedures for repayment by an applicant to the pool where such applicant, after receiving payment from the pool, recovers the costs of medical and related expenses pursuant to a settlement or judgment in a legal action;

(9) To establish procedures by which moneys in the account established under section 9 of this act shall be expended, taking into consideration payments that have been preapproved pursuant to section 7 of this act and administrative costs to be paid as set forth in section 9 of this act;

(10) To develop an asset test to be used if pool funds appear to be inadequate to cover requests for payment or reimbursement;

(11) To make publicly available and update at least annually a list of (A) medical and related expenses that are eligible to be considered for payment or reimbursement from the pool, subject to the limitations and exclusions under sections 5 and 6 of this act, and (B) exclusions established pursuant to this subsection;

(12) To establish and maintain a record, electronic or otherwise, of each applicant. Such records shall be maintained in a secure location, shall be confidential and shall not be disclosed except as required by law and to members of the commission, provided such members agree, in writing, to keep such records confidential;

(13) To disseminate information to the public concerning the pool, including, but not limited to, the benefits available from the pool, procedures to apply and contact information for said office;

(14) To enter into contracts, within the moneys available in the pool, to carry out the provisions of sections 1 to 9, inclusive, of this act,

including, but not limited to, entering into contracts with licensed physicians and clinicians to assist said office in performing its duties and to designate persons who have the appropriate expertise to assist said office in performing its duties. Nothing in this subdivision shall be construed to prohibit said office from seeking such services on a volunteer basis;

(15) To accept grants of private or federal funds to the pool, and to accept gifts, donations or bequests, including donations of services; and

(16) To take any other action necessary to carry out the provisions of sections 1 to 9, inclusive, of this act.

Sec. 5. (NEW) (*Effective July 1, 2009*) To be eligible for payment or reimbursement from the pool, a child shall:

(1) Be covered by:

(A) An individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes;

(B) A self-insured comprehensive group medical or health care benefit plan. The Office of the Healthcare Advocate shall determine what constitutes a comprehensive plan for the purposes of this subparagraph;

(C) The Municipal Employee Health Insurance Plan set forth in section 5-259 of the general statutes;

(D) A comprehensive individual or group health care plan set forth in section 38a-552 or 38a-554 of the general statutes; or

(E) A high deductible plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, used to establish a "medical savings account" or

"Archer MSA" pursuant to Section 220 of said Internal Revenue Code or a "health savings account" pursuant to Section 223 of said Internal Revenue Code, provided such medical savings account or health savings account has been exhausted and a family's subsequent medical and related expenses exceed the threshold levels established in section 6 of this act;

(2) Not be eligible for benefits under Medicaid, HUSKY Plan or state-administered general assistance on the date the medical or related expenses for which reimbursement is requested from the pool were incurred, except that a child who is eligible to receive benefits under Medicaid or HUSKY Plan and is covered by an individual or group health insurance policy or plan set forth in subdivision (1) of this section shall be eligible for payment or reimbursement from the pool;

(3) Be a resident of this state;

(4) Be a citizen or resident alien of the United States; and

(5) Have exhausted (A) other sources of third-party payment such as, but not limited to, the child's policy or plan or any applicable state programs, for the requested payment or reimbursement, and (B) all administrative remedies available under the child's policy or plan.

Sec. 6. (NEW) (*Effective July 1, 2009*) (a) All family medical and related expenses, subject to the exclusions under subsection (c) of this section, may be counted for the purposes of determining whether an applicant's family medical and related expenses exceeds the threshold levels set forth in this subsection. An applicant shall provide such documentation as is required by the Office of the Healthcare Advocate of the medical and related expenses incurred by such applicant and such applicant's family. Payment or reimbursement from the pool for medical and related expenses incurred for a child in a year shall be limited to:

(1) For family income that is less than or equal to two hundred per

cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of eight per cent of such family income;

(2) For family income that is greater than two hundred per cent but less than or equal to three hundred per cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of nine per cent of such family income;

(3) For family income that is greater than three hundred per cent but less than or equal to four hundred per cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of ten per cent of such family income;

(4) For family income that is greater than four hundred per cent but less than or equal to five hundred per cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of twelve and one-half per cent of such family income;

(5) For family income that is greater than five hundred per cent but less than or equal to one thousand per cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of fifteen per cent of such family income;

(6) For family income that is greater than one thousand per cent but less than or equal to one thousand five hundred per cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of twenty per cent of such family income;

(7) For family income that is greater than one thousand five hundred per cent but less than or equal to two thousand per cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of

twenty-five per cent of such family income; and

(8) For family income that is greater than two thousand per cent but less than or equal to two thousand five hundred per cent of the federal poverty level, medical and related expenses paid by an applicant and an applicant's family in a year that are in excess of thirty per cent of such family income.

(b) An applicant with a family income that is greater than two thousand five hundred per cent of the federal poverty level shall not be eligible for payment or reimbursement from the pool.

(c) The following shall not be counted as expenses for the purposes of determining whether an applicant's family medical and related expenses exceeds the threshold levels set forth in subsection (a) of this section, and shall be excluded from payment or reimbursement from the pool:

(1) Costs for services that would normally be provided by or available through (A) the birth-to-three program set forth in section 17a-248 of the general statutes, (B) the Department of Developmental Services, (C) the Department of Mental Health and Addiction Services, (D) the Department of Public Health, or (E) an individualized family service plan pursuant to section 17a-248e of the general statutes, an individualized education program pursuant to section 10-76d of the general statutes or any other individualized service plan. Such costs may be eligible for payment or reimbursement from the pool at the discretion of the Office of the Healthcare Advocate if the applicant was ineligible for such services due to the financial eligibility criteria of a program or agency or due to a limit on the number of clients served by such program or agency;

(2) Costs for long-term care provided in a group home, nursing home facility, rehabilitation facility, transitional or mental health facility, chronic and convalescent hospital or other residential facility, or at home that exceeds or is expected to exceed six months;

(3) Premiums, copayments, deductibles, coinsurance and other out-of-pocket expenses paid by an applicant for a long-term care policy;

(4) Premiums paid by an applicant for any health insurance policy or medical benefits plan, including, but not limited to, vision or dental plans;

(5) Items that were denied because the insured or enrollee failed to comply with the terms of the insurer such as network or prior authorization requirements;

(6) Items that are not cost-effective or appropriate for the child's medical condition, as determined by the Office of the Healthcare Advocate or persons designated by said office pursuant to subdivision (14) of section 4 of this act. Such determination may be made separately from any decision made by an insurer, health care center or utilization review company concerning such items. If said office disagrees with such decision made by an insurer, health care center or utilization review company, said office may be a party to an appeal filed by the applicant with such insurer, health care center or utilization review company;

(7) Infertility diagnosis and treatments;

(8) Massage services, natureopathy and other alternative medicine treatments or services;

(9) Dental braces, dentures, cosmetic dental procedures and routine dental services, including, but not limited to, fillings, cleanings and other prophylaxis measures;

(10) Vision correction services, including, but not limited to, LASIK surgery;

(11) Pharmaceutical products, biological products or any substance that may be lawfully sold over the counter without a prescription under the federal Food, Drug and Cosmetics Act, 21 USC 301 et. seq., as amended from time to time;

(12) Vitamins or food supplements, unless prescribed for a diagnosed medical condition;

(13) Cosmetics or anything used or worn solely to improve appearance;

(14) Services, treatments or products that are more expensive than equally effective alternatives, as determined by the Office of the Healthcare Advocate or persons designated by said office pursuant to subdivision (14) of section 4 of this act; and

(15) Other programs, services or expenses said office may choose to exclude pursuant to regulations adopted in accordance with chapter 54 of the general statutes.

Sec. 7. (NEW) (*Effective July 1, 2009*) (a) If payment of a medical or related expense is preapproved by the Office of the Healthcare Advocate:

(1) Said office shall remit such payment to the insured's or enrollee's health care provider at the Medicare allowable rate for such medical or related expense. If there is no comparable Medicare allowable rate, said office, with the advice of the Catastrophic Medical Expenses Advisory Commission, shall develop a rate based on current Medicaid and insurer rates, or on rates negotiated by the Healthcare Advocate where no current Medicaid or insurer rate exists.

(2) Said office may preapprove a payment in accordance with the rules and procedures established by said office, provided (A) the insured's or enrollee's health care or services provider has agreed, in writing, to accept such payment as payment in full on behalf of such insured or enrollee for such medical or related expense, (B) the insurer, health care center, self-insured employer, insured or enrollee, as applicable, provides any documentation or information required by said office to determine the eligibility of the applicant or the request for payment, and (C) there are sufficient funds in the pool.

(3) Said office may preapprove payment of a related expense not typically considered medical if said office or persons designated by said office pursuant to subdivision (14) of section 4 of this act deem such related expense necessary to maintaining the health of the child or the ability of such child to remain at home rather than be admitted to a health care facility.

(b) If reimbursement of a medical or related expense is approved by the Office of the Healthcare Advocate:

(1) The applicant shall submit the bill to said office with proof of payment.

(2) Said office may pay all or part of such bill, based on (A) the rate said office would have paid pursuant to subdivision (1) of subsection (a) of this section, (B) the appropriateness and necessity of the particular medical or related expense, and (C) the availability of funds in the pool.

(c) Notwithstanding any provision of the general statutes, said office shall not be deemed to be a preferred provider network, as defined in section 38a-479aa of the general statutes, or an unauthorized insurer, as defined in section 38a-1 of the general statutes.

Sec. 8. (NEW) (*Effective July 1, 2009*) (a) For the purposes of this section, the catastrophic medical expenses pool established pursuant to section 2 of this act shall be deemed to be a public assistance program.

(b) Notwithstanding the provisions of chapter 319v of the general statutes, any payment or reimbursement to an applicant from the pool shall not be counted as income by the Department of Social Services for the purposes of determining eligibility for medical assistance, but such payment or reimbursement to an applicant who is also an applicant for medical assistance pursuant to section 17b-261 of the general statutes shall be considered an incurred expense paid by a public assistance program that shall be counted for the purposes of reducing excess income of such applicant.

Sec. 9. (NEW) (*Effective July 1, 2009*) (a) There is established an account to be known as the "catastrophic medical expenses account", which shall be a separate, nonlapsing account within the Insurance Fund established under section 38a-52a of the general statutes. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Office of the Healthcare Advocate for the purposes of paying or reimbursing medical and related expenses, paying administrative costs and paying licensed physicians and clinicians contracted by said office, in accordance with this section and sections 1 to 8, inclusive, of this act.

(b) On and after January 1, 2010, each insurer, health care center or other entity that delivers, issues for delivery, renews, amends or continues in this state an individual or group health insurance policy or plan set forth in section 5 of this act and third-party administrator that provides services in this state under an administrative services only contract for a policy or plan set forth in section 5 of this act shall collect one dollar per life covered in this state from each insured or policyholder at the time of renewal and shall remit such moneys to the Office of the Healthcare Advocate not later than thirty days after collection. All such moneys shall be deposited in the account set forth in subsection (a) of this section. A policyholder that has collected and paid such moneys pursuant to this subsection may collect one dollar from each person insured under such policy, provided the total amount collected from such insureds shall not exceed the total amount paid by such policyholder to said office.

(c) The Commissioner of Social Services shall seek any federal matching funds available for the pool.

(d) When the moneys in the account have been exhausted, no payments or reimbursements shall be made until moneys have been deposited pursuant to subsection (b) of this section.

Sec. 10. Section 38a-1041 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(a) There is established an Office of the Healthcare Advocate which shall be within the Insurance Department for administrative purposes only.

(b) The Office of the Healthcare Advocate may:

(1) Assist health insurance consumers with managed care plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services;

(2) Assist health insurance consumers to understand their rights and responsibilities under managed care plans;

(3) Provide information to the public, agencies, legislators and others regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns;

(4) Assist consumers with the filing of complaints and appeals, including filing appeals with a managed care organization's internal appeal or grievance process and the external appeal process established under section 38a-478n;

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to health insurance consumers and recommend changes it deems necessary;

(6) Facilitate public comment on laws, regulations and policies, including policies and actions of health insurers;

(7) Ensure that health insurance consumers have timely access to the services provided by the office;

(8) Review the health insurance records of a consumer who has provided written consent for such review;

(9) Create and make available to employers a notice, suitable for

posting in the workplace, concerning the services that the Healthcare Advocate provides;

(10) Establish a toll-free number, or any other free calling option, to allow customer access to the services provided by the Healthcare Advocate;

(11) Pursue administrative remedies on behalf of and with the consent of any health insurance consumers;

(12) Adopt regulations, pursuant to chapter 54, to carry out the provisions of sections 38a-1040 to 38a-1050, inclusive; and

(13) Take any other actions necessary to fulfill the purposes of sections 38a-1040 to 38a-1050, inclusive.

(c) The Office of the Healthcare Advocate shall make a referral to the Insurance Commissioner if the Healthcare Advocate finds that a preferred provider network may have engaged in a pattern or practice that may be in violation of sections 38a-226 to 38a-226d, inclusive, 38a-479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

(d) The Healthcare Advocate and the Insurance Commissioner shall jointly compile a list of complaints received against managed care organizations and preferred provider networks and the commissioner shall maintain the list, except the names of complainants shall not be disclosed if such disclosure would violate the provisions of section 4-61dd or 38a-1045.

(e) On or before October 1, 2005, the Managed Care Ombudsman, in consultation with the Community Mental Health Strategy Board, established under section 17a-485b, shall establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3)

the relative costs and benefits of providing effective mental health care coverage to employees and their families. On or before January 1, 2006, and annually thereafter, the Healthcare Advocate shall report, in accordance with the provisions of section 11-4a, on the implementation of this subsection to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance.

(f) On or before October 1, 2008, the Office of the Healthcare Advocate shall, within available appropriations, establish and maintain a healthcare consumer information web site on the Internet for use by the public in obtaining healthcare information, including but not limited to: (1) The availability of wellness programs in various regions of Connecticut, such as disease prevention and health promotion programs; (2) quality and experience data from hospitals licensed in this state; and (3) a link to the consumer report card developed and distributed by the Insurance Commissioner pursuant to section 38a-478*l*.

(g) The Office of the Healthcare Advocate shall administer the catastrophic medical expenses pool established under section 2 of this act and carry out the provisions of sections 1 to 9, inclusive, of this act, with the assistance and advice of the Catastrophic Medical Expenses Advisory Commission established under section 3 of this act. Said office shall adopt regulations, in accordance with chapter 54, to implement the provisions of sections 1 to 9, inclusive, of this act."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	New section
Sec. 2	*July 1, 2009*	New section
Sec. 3	*July 1, 2009*	New section
Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	New section
Sec. 6	*July 1, 2009*	New section
Sec. 7	*July 1, 2009*	New section

Sec. 8	*July 1, 2009*	New section
Sec. 9	*July 1, 2009*	New section
Sec. 10	*July 1, 2009*	38a-1041